VERBATIM PROCEEDINGS

CONNECTICUT HEALTH INSURANCE EXCHANGE

SMALL EMPLOYER HEALTH OPTIONS PROGRAM
ADVISORY COMMITTEE MEETING

APRIL 11, 2012

DEPARTMENT OF PUBLIC HEALTH
470 CAPITOL AVENUE
HARTFORD, CONNECTICUT

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. . .Verbatim proceedings of a meeting before the Connecticut Health Insurance Exchange, Small Employer Health Options Program Advisory Committee Meeting, held at the Department of Public Health, 470 Capitol Avenue, Hartford, Connecticut, on April 11, 2012 at 2:03 p.m. . . .

MS. TIA CINTRON: So welcome. We really appreciate you being here this afternoon and for taking time to dedicate to this important project of ours. We have a lot to accomplish in the next nine months and want to kind of walk you through some of those priorities and give you an overview, in terms of what we're looking at for State certification and how that applies to this group.

We're going to try to talk with you about how this group will be matrixed and interact with the other Advisory Committees. I'm getting ahead of myself. Let's do some introductions.

My name is Tia Cintron, and I'm the acting CEO for the Exchange, and would you start, Nellie, with your introduction?

MS. NELLIE O'GARA: My name is Nellie O'Gara. I'm going to be your facilitator, and, for some of you who don't know me, I facilitated the first group of stakeholder meetings last May, so I'm happy to be back and see the continuation.

MR. BOB CAREY: And I'm Bob Carey. I'm a consultant to the Exchange. My background is that I was the Director of Policy and Development for the Mass. Connector from its inception throughout the first couple of years.

Most recently, I've been working with a number of states on the implementation of Exchanges. I do work, also, for the federal government for what's called the Federally-Facilitated Exchanges, which will be those Exchanges in states that don't achieve certification and are able and ready to operate an Exchange by the middle of 2013.

My background, prior to working at the Connector, is that I was basically the purchaser of health insurance for State employees and retirees in Massachusetts, which is about 350,000 people, so my background is really on the commercial side, as both the purchaser and then as a person to help set up and operate the Mass. Connector.

MS. MARY ELLEN BREAULT: Mary Ellen Breault. I'm the Director of the Life and Health Division at the Insurance Department, and I've been at the Department for 20 years, and, before that, I was at Travelers as a Pricing Actuary in the health insurance area.

And I actually was part of the development work in the early 1990s for the Connecticut Small Employer Reform, so I've kind of been here through all of that, and I'm still an ex officio member of the Insurance Department representative, so I've been helping the Exchange out with various projects, and I'm here to provide any technical assistance.

MS. LYNN JANCZAK: Good afternoon. My name is Lynn Janczak. I'm the Vice President of Communications and Marketing for Learning Dynamics. We are an executive training company, based in Wallingford, Connecticut.

My background is I was at Travelers in Managed Care and Employee Benefits for five years before the buyout came, and then I went to Wall Street, where I was with Smith Barney in International Currencies for three years, so I do have a background in Managed Care and Employee Benefits.

My group was a small group at the Travelers, from 2,000 to 5,000 employees. They considered 5,000 still small at that time. So I'm very happy to be here.

MS. MARTA MACIUBA: My name is Marta Maciuba. I am currently the Service and Sales Director for Small Group for Aetna in the New England Marketplace. I also have been a part of the underwriting teams and was an Underwriting Manager for 10 years at Aetna, as well, before I went into sales.

I, as well, have been on Wall Street and worked on the Chicago Board Options Exchange as a broker for the defunct Drexel Burnham years ago in the '80s, so my background is more finance than sales over the last five years.

MS. PAMELA RUSSEK: I'm Pam Russek. I'm the Stakeholder co-Chair for this Committee, and I'm currently an independent consultant, focusing primarily on small and medium-sized businesses.

Number of lines doesn't -- our employees tend to enter into some of which is revenue targets, so companies usually with revenues over two and a half million and up.

My background many years in Cigna, Aetna,

WellPoint, United Health Care, and having responsibility for underwriting and marketing of individual small groups and currently advising small business clients in the H.R. and E.B. space, among other things.

MS. MARJORIE COLE: I'm Marjorie Cole. I work for Hartford Health Care Corporation. Prior to that, I was at Oxford and United, where I did contracting and negotiations for the New York, New Jersey, Massachusetts market and Connecticut market.

And, before that, I ran an independent physician association in the Ridgefield/Danbury area, as well as ran a multi-specialty physician office.

MR. TIMOTHY PUSCH: Hi. My name is Tim Pusch. I work for the Burns, Brooks and McNeil Insurance Agency. I've been a health broker, focusing on small business, defined as under 50, for the last 14 years.

Prior to that, I worked for health insurance carriers, several of them, in the home office area and got a pretty wide array of experiences doing that before becoming an independent insurance broker.

MR. JOHN FLEIG: Hi. I'm John Fleig with United Health Care.

MR. ANTONIO PINTO: Antonio Pinto, and, as of last week, I'm now a Telephone System Consultant, so I

went back to my IT roots, but I spent 10 of the 12 last years working with small businesses, primarily sole providers, individuals and companies with fewer than 10 employees here in Connecticut as an insurance agent and consultant.

MS. CINTRON: Grant, would you like to introduce yourself, please? Grant?

MR. GRANT RITTER: Hi. Grant Ritter. I'm a Health Economist at Brandeis University. I've been working in Health Services Research for about 20 years. I do a lot of work with CMS.

I like to measure things. I looked at quality, I looked at efficiency, I looked at cost, I looked at a lot of things that revolve around rates and the costs that they see.

More recently, I worked with value-based purchasing ideas for hospitals and, more recently, for physicians, and now I'm working on underpayment and episode group agencies --

MS. CINTRON: Okay, thank you. Oh, Matt. Dr. Katz?

MR. MATTHEW KATZ: First of all, I don't know if Grant is having the same problem, but there's a large echo on the phone, and it's a little hard to hear

people. I don't know if there's a single microphone on the phonecom(phonetic) or if there are multiple microphones, but there seems to be a lot of echoing.

MS. CINTRON: Okay. We might put you closer to, because of Bob's role here, it might be better to --

MR. KATZ: Do you want me to give my quick background?

MS. CINTRON: That would be helpful. Thank you.

MR. KATZ: Yes. I'm the Executive Vice President and CEO of the Connecticut State Medical Society. I've been in Connecticut for six years. Prior to that, I ran various areas and departments for the American Medical Association, American Academy of Pediatrics.

I have worked for hospitals, hospital assistants, and health insurers, as well, and I sit on the Board of a number of regional and national organizations that look at health care, and I published peer reviewed articles and researched types of health equity and physician workforce.

MS. CINTRON: All right, thank you. It's not acoustically ideal here. So we, today, walking

through a few logistics, we are -- these meetings will be recorded and transcribed. The transcriptions will be posted to our web page within seven to 10 days.

So when you do speak, if you could first state your name, and then kind of speak into the microphone, that would be helpful. Cell phones off. Bathrooms are down the way there, if you need.

I want to just walk you through our agenda today. So, as you know, there are four Advisory Committees that we have established that are all kind of geared to want we need to accomplish as a state, gearing towards successful State certification in January of next year.

So along this next nine months, we have a pretty ambitious set of tasks that we need to do collectively, so the four Committees are supporting that end goal and will be walking through today how we're going to cross-walk these committees, how you'll be collaborating with one another, and your specific tasks in the next nine months or so.

Bob will be going over our draft of guiding principles, which will kind of be our overarching objectives for this Committee, as well as the priority, specific priority tasks and the resources that we have

available and want to help guide this discussion, as well as the Next Steps, and then we do have some time that we can dedicate to public comment, if needed.

So State certification, again, is a pretty significant milestone for us as a state, because we will be looked at operationally and very comprehensively. There's a series of three gate reviews that we will be -- the term that the feds are using for basically looking at our operational and functional readiness to become a State Exchange.

We had our first pre-planning gate last week in D.C., which looked at really just our approach, in general, and a work plan that we had developed, and, in another six weeks, we will have our first planning gate review, then that's followed by a design and an implementation.

So those are kind of milestones or benchmarks, if you will, to have assessment points for the feds to look at as a state, with a final goal of successful application to become a State-based Exchange.

So, with that, I think, Bob, I'm going to turn it over to you to talk through how this Committee will be working with others over the next few months, as well as the priority tasks.

MR. CAREY: Sure. This is Bob Carey. So we set up these four Committees, and, as we started to walk through the responsibilities and roles of each Committee, we quickly discovered that there is overlap in some of the issues that one Committee may be looking at vis-à-vis another Committee, and, so, we began to layout sort of a plan for how we address issues that may touch on multiple Advisory Committees.

And, so, for example, the Qualified Health Plan Advisory Committee will be recommending the types of qualified health plans that are made available for the individual and small group market.

We also think it's important for this Committee, which is focused exclusively on the SHOP Exchange and the small group market, to have some input and some comment and recommendation on the type of plans that may be available particular to the small group market.

So we've set up the structure of each of the Advisory Committees, so that for those issues that may affect multiple Advisory Committees, there will be a process by which one Committee's recommendations will essentially be vetted by and reviewed and commented on by another Advisory Committee.

And, so, the Essential Health Benefits or the Qualified Health Plan Advisory Committee, for example, will develop a set of recommendations with regard to the types of plans and the number of plans that are offered in the small group market, but this Advisory Committee will also weigh in on its views of recommendations to the Board, so the Advisory Committees are not sort of the decision-making bodies.

The Exchange Board is the ultimate decision-making body, but we believe that expertise and advice from this Advisory Committee to the Exchange Board on an issue, such as what types of plans should be offered in the small group market, will be important, so that the Exchange Board understands the viewpoints of both the SHOP Advisory Committee and the Qualified Health Plan Advisory Committee, so that's just sort of an example.

And we have a number -- you'll see, as we walk through the tasks and the resources, we have a number of issues that we've already flagged as those that cut across multiple Advisory Committees.

So the second manner by which we think we'll be able to minimize any conflict across or among Advisory Committees is the development of guiding

principles, both at the Exchange Board level, so the Exchange Board is going through the process of developing guiding principles for its decision-making at the upper level of the Exchange Board, and then each of the Advisory Committees, and we've set up a draft guiding principles, which you'll review and comment on and revise during today's meeting, but we think that those guiding principles, which we'll share the guiding principles from each of the Advisory Committees with each other, so you'll see, hopefully, that they're in concert with one another with regard to any sort of overriding principles that will help you make decisions and recommendations.

The third way that we are hopeful that there will be some commonality in recommendations across Committees is by having Exchange staff publicize the information, as provided, feed information to different Advisory Committees from each of the Advisory Committee's work that may touch on it, and, also, by the Board co-Chair reporting at each Board meeting to the broader Exchange Board on the work of each Advisory Committee.

So as we move forward, there will be an update on a regular basis across Advisory Committees, and then from the Advisory Committee up to the Exchange Board.

So we think we laid out a number of ways in which we'll be able to minimize any type of conflicting recommendations, or recommendations that may touch on one Advisory Committee that another Advisory Committee may want to have some input to.

So, instead of having a Committee as a whole, we decided we'd break up the tasks into these four Advisory Committees, recognizing that there is some overlap across Advisory Committees.

MS. CINTRON: Would you mind introducing yourself?

MS. PATRICIA PULISCIANO: Not at all. Patty Pulisciano.

MS. CINTRON: Thank you.

MR. CAREY: And we had another gentleman join us.

MR. CHRISTOPHER McKIERNAN: Chris McKiernan -- (indiscernible - too far from microphone).

MS. CINTRON: Thank you.

MR. CAREY: So that's just sort of the general sort of procedurally or the way in which we hopefully will be able to share information across Advisory Committees on issues that cut across the various Advisory Committees.

I don't know if there are any questions or comments on that. We'll make it work. That was number one.

We thought it might be helpful, just to level set, if I spent a few minutes talking about the distinction between the SHOP Exchange and the Individual Exchange.

MS. CINTRON: Would that be helpful?

MR. CAREY: Okay, so, the way that the law is set out, it directs the states to set up Exchanges, and then, essentially, directs the states to offer two programs, or target two markets.

The first market is the individual market. That's for people, who are uninsured, or currently have insurance through the non-group market on the individual market, people, who are not offered employer-sponsored insurance, people, who are not eligible for Medicaid or Medicare, and people for whom they may be able to access premium subsidies, a reduced cost share, so that's a market.

That's a separate program, essentially, that the Exchange will be responsible for running. There are 377,000 or so individuals, who are uninsured in Connecticut. There are people, who are purchasing

coverage on their own in the non-group market, who may be eligible for subsidies through the Individual Exchange.

And, so, that Individual Exchange will have a process by which eligibility is determined, based on, you know, not having access to employee-sponsored insurance, not being eligible for Medicaid and Medicare, what their income level is, and then what any potential subsidy amount directly to the consumer or the individual to help that person purchase insurance in the individual market.

So think about it as a separate program run by the Exchange for individuals, who don't have access to employer-sponsored insurance and meet other eligibility criteria. Yes, sir?

MR. PUSCH: Do they have to be turned down my Medicaid before they could then turn to the Exchange?

MR. CAREY: They cannot be eligible for Medicaid, so someone wouldn't necessarily have to go through the application process to make themselves, you know, to confirm that they're not eligible for Medicaid, so someone, perhaps, you know, who is a single person, making $40,000 a year, is, you know, not eligible for Medicaid, they don't have to go through that whole process, but you cannot be eligible for Medicaid and turn

down Medicaid and then opt for the Exchange.

MR. McKIERNAN: Will the onus be on the individual, in terms of providing information to a certain group?

MR. CAREY: Yeah, so, there's a whole eligibility determination process. You raised a good point. So we're working on a sort of separate stream to establish a system that enables an individual to complete an application to be determined eligible potentially for subsidies or just in general eligible for insurance coverage through the Exchange, so there will be an application process and an eligibility determination that's made for those individuals, for the Individual Exchange.

MS. BREAULT: I'm not sure if I heard it. Are you saying Husky, or Charter Oak? How does that all come into play?

MR. CAREY: Right, so, there will be instances, in which, you know, the kids may be eligible for Husky, and mom and dad may be eligible for the Exchange, so you'll have these split families.

MS. BREAULT: (Indiscernible - too far from microphone).

MR. CAREY: To the best of our knowledge,

they'll exist, I guess, you know? All bets are off until November, I think, but, yeah. So there will be multiple programs, and, so, if people come through the concept with regard to the individual, non-group, non-employer, is that they'll fill out a single application and be determined either for, you know, Medicaid, the kids may be eligible for Husky, and then, if they're not eligible for Medicaid or Husky, they may be eligible for subsidies through the Exchange. So that's the individual market.

The law also directs states to set up the SHOP Exchanges for small employers, and, initially, the definition of small employer can be limited, as it is today, to groups of up to 50 employees, with the State option to expand that definition in 2014 or 2015 to groups with up to 100 employees.

In 2016, states are required to expand their definition of small employer to groups with up to 100 employees. So, in 2016, it will be required that the small group definition in Connecticut be changed from groups of up to 50 to groups of up to 100 employees, and those small groups will be eligible to purchase coverage through the SHOP Exchange.

So the employer comes to the SHOP Exchange, brings with him or her their employees to

purchase coverage through the SHOP Exchange. There's no subsidy for the individual, so even if an individual might be eligible, based on their income, for subsidized coverage to the Individual Exchange, if the employer is offering them coverage and the employer is contributing a minimum amount, based on the individual's income, that individual is not eligible for subsidies, but, as a group, they will come, they can come and purchase coverage through the SHOP Exchange.

MR. McKIERNAN: Is there a group subsidy?

MR. CAREY: There's a group subsidy for small groups, less than 50 employees, and it's on a scale, so that it's a subsidy for the employer for his or her share of the premium. It's not for the individual members.

So for a small employer, with low-wage workers, that offers employer-sponsored insurance, that purchases coverage through the SHOP Exchange, may be eligible for a time limited subsidy of up to two years for the employer's share of the premium.

That's available today in the market. There hasn't been a whole -- there hasn't been a large take-up, in terms of people applying for that subsidy, but it expands, in terms of the value of the subsidy, in

2014, and it's limited to only those groups that purchase coverage through the SHOP Exchange.

MR. PUSCH: It's sort of based on the average earnings of the employees, like today?

MR. CAREY: Correct.

MS. PULISCIANO: And that's in the form of tax credit?

MR. CAREY: That's in forms of the tax credit, right. It's not an advanced tax credit. It's an end-of-year tax credit, as it exists today. It's just an expansion of that, in terms of the amount, percentage of the premium that the small employer can recoup from the federal government for those low-wage workers.

MR. McKIERNAN: I would assume that normal group laws will, similar to in the current marketplace, the small group marketplace, similar rules will apply, in terms of percentage of participation amongst eligible employees.

MR. CAREY: Sir, that's on our list of things to discuss and recommend. So the comment was pertains to any underwriting requirements with regard to contribution or participation that exists in the marketplace today, and will those same requirements apply in the SHOP Exchange, so that's sort of on our list of

to-dos, is to discuss and to determine whether that makes sense, to mimic what goes on in the outside market.

I think it's also important to recognize that there will be, continue to be a marketplace outside of the SHOP Exchange. There's no requirement that small employers purchase coverage through the SHOP Exchange. It's my experience that that marketplace will continue to operate maybe differently, given all of the other changes under the ACA, but that there will be a robust, small group marketplace outside of the Exchange.

So the Exchange, particularly on the SHOP side, is a distribution channel, one of probably many, that are available in the Connecticut marketplace.

Connecticut, of course, is also quite different than almost any other states, in that you sort of have a SHOP Exchange right now with the Health Connections program that is run by CBIA.

So, essentially, if you think about other than there are other requirements under a Public Exchange, or an Exchange under the ACA, the model that CBIA developed and offers to employers and employees is quite comparable to the requirements of the ACA and the SHOP Exchange under the federal law.

MS. JANCZAK: I have a question.

MR. CAREY: Sure.

MS. JANCZAK: This is Lynn Janczak. I think that this is all great going forward, but is there anything that is contingent on any federal legislation with regard to health care changes that will inevitably be coming up within the next four or five years?

MR. CAREY: So a couple of comments in response. One is that, you know, our view is that, you know, we have to move forward, based on existing law and existing timelines, and we recognize, you know, there are those, you know, nine people in D.C., who are huddling to determine constitutionality of the law and will have to adjust accordingly if, in June, they, you know, change things or throw things out.

There will be an election in November. We don't know what the future holds, but, you know, the timelines are such that we can't wait. We have to move forward and make certain decisions, and then, depending on how the situation changes, we'll likely have to change some of those decisions that we make, but you raise a good point.

It was raised this morning at our Advisory Committee, you know, what's Plan B, or what's the alternative, and I guess, since we don't know, you know,

exactly what will happen, we have to sort of march forward under existing rules, and then, you know, shift, as necessary.

MS. JANCZAK: Thank you.

MR. CAREY: So there's lots of decision points with regard to the SHOP Exchange and how it's structured, and there's some, you know, general guidance from the federal government in the form of both guidance and bulletins and regulation, but, within that, there are options that are available to states, and that's what we need your help with, is to walk through some of those options and how we're going to structure the SHOP Exchange, what type of purchasing model do we make available to employers?

How do we entice carriers to participate in the SHOP Exchange? What are the premium contribution and participation requirements? What types of plans do we offer? And, so, there are a whole series of issues that we'll walk through, and when we start to get in later in the meeting and the tasks, we can have a bit more discussion about each one of those individually and the timeline that we laid out, in terms of when those decisions need to be made.

So any questions sort of in general? I

realize that was sort of a quick overview of the SHOP Exchange, but I just wanted to make sure folks understood, you know, the significant distinctions between the Individual Exchange and the SHOP Exchange.

I think the biggest difference is individuals purchasing through the SHOP Exchange. Employees purchasing through the SHOP Exchange don't go through an eligibility process, the same way that an individual purchaser, who doesn't have an employer-sponsored insurance with them, will be able to get access to coverage through the Individual Exchange.

MR. PUSCH: In other words, no underwriting?

MR. CAREY: No. In other words, no income-based criteria to determine whether you're eligible to purchase insurance. The underwriting rules in that I guess are -- that's a whole separate discussion about all of the changes with regard to the manner by which insurance is sold, in general, and we can talk about that further.

My point was that, in terms of the ability of an individual to purchase insurance through the Individual Exchange, they'll have to go through an eligibility determination process that the employees of

an employer won't have to go through, so it's just sort of a different way in which people will access coverage.

MR. McKIERNAN: So it does not preclude, say, an individual, who works for an employer, dependent upon what the contribution percentage is? An employee from that group that may participate in the SHOP program could still be eligible to take the individual route instead of the group route through their employer?

MR. CAREY: Yeah, so, if an individual is offered employer-sponsored insurance and the individual's share of the premium, not the total premium, the individual's portion of the premium is greater than nine and a half percent of his or her income, that individual could decline the employer-sponsored insurance and come through the Individual Exchange, whether that employer is participating in the SHOP, or just buying it direct from the carrier, so there are instances in which individuals, who are offered employer-sponsored insurance, may be eligible for subsidies through the Individual Exchange.

The other criteria with regard to the type of coverage, so the coverage has to be affordable, meaning less than nine and a half percent of his or her income as a share of the premium, and it has to meet the minimum standard of that 60 percent actuarial value

standard.

So if you're an employee and you're offered insurance and the insurance doesn't meet that 60 percent threshold, you could come through the Individual Exchange and be determined eligible for subsidy and purchase that way.

A FEMALE VOICE: (Indiscernible - too far from microphone).

MR. CAREY: Employers with over 50 -- with 50 or more employees in that instance could face a penalty for those employees that come through the individual side and get a subsidy.

MR. PINTO: Actually, I was going to make a comment as a frame of reference.

MS. O'GARA: Antonio?

MR. PINTO: Yes. Antonio Pinto. Sorry. Tony is fine. There is a summary report that was done through Mercer that was given to the Board a couple of months ago that's available online. It has a lot of the background work.

And the Kaiser Family Foundation also has a great article on summarizing health care reform. It's far more detailed than what we're going to do here, but they do summarize it fairly well, as far as the subsidies

and, you know, the under 50 market is actually very defined to even under 30, because the first 30 employees are exempt.

So I can send it to you, or you can get it off the website. I think between the Mercer, or the summary of it, even though it might be a little flawed, and the Kaiser Family Foundation information, I think you'll get a lot of background to what we really are going to be looking at going forward, as far as who is going to enroll, how are they going to enroll.

For instance, you know, those of us in the business know that if you're a group of one and you have health issues, you don't have guaranteed issues, so you try to make them a group of two and get them coverage through our own reform pool, which is the under 50 market in Connecticut is really a reform pool that's been around for 17 years now.

So there is a lot of things that are going to come into play when you start looking at individual versus small group, especially those groups of under 30 employees.

MS. O'GARA: Chris, could you say your name?

MR. McKIERNAN: Sure. Chris McKiernan.

You know this is all precluding the fact that, in June, with the Supreme Court ruling and the individual mandate, I would think that underwriting laws would change, both on the individual market, obviously, and the group market with this individual mandate.

The whole marketplace is going to somewhat have to change, in order to comply with these new rules.

MR. PINTO: It's Tony Pinto again. Just to comment on that, if the individual mandate is eliminated, assuming nothing else happens, one of the keys to the health care reform is there's two components.

One is guaranteed issue. If guaranteed issue goes into effect, that does completely change the market, and what people pay is based on their income, so your income level decides what you're going to pay for health care.

So if you're under I think it's 400 percent of federal poverty level, you get a subsidy, but at 200 percent of federal poverty level, you're only paying three percent of your income, two to three percent of your income for health care.

If the plan is a $10,000 plan, what you pay to access care, the health plan for the Exchange is driven by your personal income. Even without the

individual mandate, it addresses the preexisting conditions and the affordability.

MS. O'GARA: Okay.

MS. CINTRON: Before we go any farther, Ellen, would you introduce yourself?

MS. ELLEN SKINNER: I'm Ellen Skinner from the Office of Group Management. I have an insurance background and work for (indiscernible -- too far from microphone).

MS. CINTRON: Welcome. Thank you. And, just as a check, Dr. Katz and Grant, are you able to hear everything?

MR. RITTER: We're able to hear the responses, but not the questions.

MS. CINTRON: Okay, so, we'll all try to do a better job of speaking up, if that will be helpful. Sorry, Nellie.

MS. O'GARA: Okay, so, given that background from Bob, what we want to do next is talk about guiding principles for this particular set of activities, and what we mean by that we're trying to put in place a number of principles that will help us make decisions, will guide us as we go forward.

Bob has written some for your

consideration, and we'd like to go through each one of them now and talk about them and see whether you want to modify them, add to them, clarify them, so we'll take a few minutes to do that.

When you do weigh in, if you could state your name, because we are recording this? It will be easier for the transcription.

So the first principle is the SHOP Exchange should provide employees with a broad choice of health plans from a number of health insurers.

The key concept there is a broad choice of health plans from a number of insurers. And, as a guiding principle, I'd ask you if that is meaningful, and if that's an appropriate guiding principle. Tim?

MR. PUSCH: Tim Pusch. Broad is an ill-defined term, as you can well imagine. Most carriers think they have a broad selection of health plans, but I will tell you there's one carrier that has this many health plans, and there's another carrier that has this many health plans.

And I just want to inject that if broad is too broad, it will make it more difficult and confusing. I tried to reduce choice to some degree with my customers, simply because you can overwhelm them with

choice, so I just would want to keep in mind the practicality of too broad a selection of plan options.

MS. O'GARA: Okay. Is there another way you'd like to phrase that, so that we are more sensitive to them, a reasonable choice?

MR. PUSCH: Sure.

MS. O'GARA: I'm asking.

MR. PUSCH: The term escapes me, as to what to say.

MS. O'GARA: What's the sense of the group?

MR. FLEIG: This is John Fleig.

MS. O'GARA: John Fleig.

MR. FLEIG: You can just take out the word broad and just leave choice and health plans, and then it's not really defined.

MS. PULISCIANO: Patty Pulisciano. I was just going to say reword it in a different manner, but if it's categorized, maybe based on category and limit, based on HSA versus maybe a hospital deductible.

MS. O'GARA: Could you speak louder, Patty?

MS. PULISCIANO: Sure.

MS. O'GARA: Could we get her the

microphone.

MS. PULISCIANO: I said, instead of using the word broad, or redefining that word, because it's always going to be open to interpretation, if you base it on categories and say, you know, two plans, based on this category, two plans, based on another category, then each carrier allows to -- allow each of those plans, based on that criteria, that might make sense.

MS. SKINNER: Ellen Skinner. I think the number of the health insurers is the important phrase there, in that you want to have choice. You want to be able to provide the consumers a choice of health plans.

I think it's fairly well-defined if we go back to the Silver, Gold and Bronze plans. Those will be defined, but number of health insurers, we want to make sure we have for-profits, not-for-profits, if there are community health care plans that are in the mix, that there should be a number of health insurers in that mix.

MS. O'GARA: So, as a suggestion, some of the ways we've tried to clarify and, at the same time, not get too specific, because we want these principles to stay in place for a little while.

COURT REPORTER: One moment, please.

MS. O'GARA: So some of the other Advisory

Committees have gone to providing examples, so what we could do here is to take out the word broad and have a choice of health plans from a number of health insurers, e.g., for-profit, not-for-profit, community-based.

MS. SKINNER: That would work.

MS. O'GARA: That would work for you. Okay. There's a few more that I want to dig into. Yes, Tim?

MR. PUSCH: Well I'd be careful with that, too. Tim Pusch. I'd be careful with that, too, because I don't know to what degree right now those various alternatives are even practically possible.

If you look at what's in the state today, I don't know of any community-based health plans or not-for-profit health plans, per se.

So unless you have some expectation that these things, these entities are going to come into existence in this whole process, I'm at a loss of what those might be.

MS. O'GARA: Marjorie?

MS. COLE: Marjorie Cole. So when you're talking about broad choice for the employees, what is it the employees are -- first of all, what are they going to understand, because if you put out not-for-profit, all

this other stuff, it's going to overwhelm them and confuse them, like we were saying, too many choices. What's in that broad choice? Is that what we really want to define, is what's in the broad choice?

MS. O'GARA: Bob, you want to weigh in on that one?

MR. CAREY: Well the concept is I mean the SHOP Exchange, sort of by definition, is set up to allow for employee choice. It's to drive down essentially the decision-making from the employer to the employee level, and, so, what we're trying to just get agreement on is that's what, you know, we want to try to achieve with this SHOP Exchange, is to provide employees with choice from a number of health insurers.

Whether that's broad or narrow choice and the type of health insurer, I think we'll probably work out those details later, but I think that the concept was to get general buy-in that there be choice, and then we'll work through other ones and how choice affects other issues, but in terms of just a choice of plans from a number of health insurers.

I mean there's different ways to structure SHOP Exchange. There's a narrow choice to, you know, the Wild West, and choose any health plan available.

MS. COLE: Then just remove the word broad.

MS. O'GARA: Okay, so, we'll leave it choice in health plans and a number of health insurers. Is that what I'm hearing from the group? And there's one comment?

MS. JANCZAK: This is Lynn Janczak. I was just fooling around with this, and I came up with the SHOP Exchange should provide employers with targeted appropriate coverages offered by a number of health insurers, and, that way, it kind of alludes to the fact that the insured gets to pick something that's targeted and for their needs, targeted appropriate coverages.

Some people need mental nervous, you know, and that's traditionally been underfunded. Some people need family plans. Others need individual, you know, only for one person.

MS. O'GARA: I guess I'm hearing from the group you don't want to get that specific at this point.

MS. JANCZAK: Okay.

MR. PUSCH: Not on the guiding principles.

MS. O'GARA: Not on the guiding, but we will need to get into that at some point. Yes, Pam?

MS. RUSSEK: This is Pam Russek. I just

want to sort of reinforce, and I'm not trying to shut down discussions by any means, but these are the guiding principles for outside the Committee, and I actually think perhaps the more valuable piece of what we're going to do in the next how many minutes with these principles is discuss them, so that we have a common understanding.

And I would tend to worry a little less about the precision of the words and more about what sort of consensus we come to today and understanding with one other about how we want to conduct ourselves in building this. Just a thought.

MS. O'GARA: Yeah. Thank you. So what I think I'm hearing is that we like the idea of choice for the employee and a variety of plans from a number of health insurers. Let's leave that one done, that change.

The second one that we're putting there for your consideration is the SHOP Exchange strives to increase the number of employers that offer employer-sponsored insurance.

There's a lot of nods of heads with that. That's pretty clear what we're saying there, right? Okay.

The SHOP Exchange purchasing model should be structured, so that employee choice does not result in

risk selection problems for health insurers and adversely affect the cost of coverage. So let's have a little discussion about that one and see what we need. Tim?

MR. PUSCH: Tim Pusch. Wouldn't that be up to the insurers to price their product appropriately to offset that or to keep that in check?

MR. CAREY: Well not necessarily. So we'll go through purchasing model options that are available for the SHOP Exchange, so, for example, within the tins, Platinum, Gold, Silver and Bronze, you could structure a purchasing model that limits choice to carriers and plans within a particular tin.

So, for example, the employer could go in and say I'm going to offer my employees the Silver level plans. They're all at 70 percent actuarial value.

We might want to offer, you know, a carrier might want a plan with a deductible, another carrier might want to offer a plan with no deductible, but higher coinsurance, and, so, there would be some variety potentially within an actuarial value, but the percentage of the medical claims paid for by the carrier are essentially the same, you know, on average, 70 percent, so that an employee could go in and say I'm, you know, my husband is sick, I'm going to get the Platinum

plan, because I know that he or she is, you know, uses lots of medical services, and I'm willing to pay a higher premium in exchange for, you know, lower co-pays.

Then the young guy comes in and says, gees, I'm going to take the Bronze level plan, because I'm young and healthy, and I'm not going to use any services, and, so, you get this separation of risk across coverage tiers, between Platinum, Gold, Silver and Bronze, and carriers typically don't, when they price a group, they're pricing the group, based on the plan design that is offered to that group.

And, so, there is the potential for risk segmentation when you offer, you know, that choice across coverage tiers, or across metallic tiers.

MR. PUSCH: Tim Pusch again. Sorry to be speaking so much. Except that, for the most part, and, please, other brokers at the table correct me if I'm wrong, for the most part, employers offer more than one plan option, and, in fact, that anti-risk selection does go on, and employees can choose, very often, it's not just one plan, and they'll peg their contribution on the base plan and allow employees to buy up, and that kind of decision and choice goes on quite frequently.

MR. CAREY: So a couple of things on that.

One is, carriers typically pair plans, so it's not like you have this wide dispersion in the value of the plans. There might be a high and low option, but the carrier restricts what the low is and what the high is, so that's one issue.

The other issue is the carrier gets all of the risk in that situation, so you're not splintering groups, you know, where two people go to Anthem, and two go to ConnectiCare, and a third goes to Aetna.

MR. PUSCH: Other than CBIA.

MR. CAREY: Other than CBIA, correct.

MR. PUSCH: Which they can do that?

MR. CAREY: Right, but there's also limits to the value of the plans in CBIA, so they structure their plan design, so that the carriers are willing to participate in that type of marketplace, and we'll go through this when we get talking about the purchasing model.

We'll need to take this into consideration, about how you structure the purchasing option, particularly when you have a situation, which people can move across tins and across carriers.

MR. McKIERNAN: Chris McKiernan. I think it comes down to pricing of the model, too. I mean in

the current group market, small group marketplace, there's gender rated, there's an age rating. It's all kind of put into one pool, and what's the indication here, as to the pricing mechanism that's going to be present in this one?

MR. PINTO: Can I jump in? Tony Pinto. I just want to comment on the earlier one. When looking at the options being offered, through the Exchange, we're talking about an employer offering within one tin.

It doesn't mean they have to go to the Exchange. They could stay outside the Exchange and offer their different plans and have the different options.

This is another avenue of purchase, so if they go to the Exchange, they would have to stay within certain guidelines, but outside the Exchange is a different market, so there is variance that should be allowed, so they'll have different choices.

MS. O'GARA: So is the intent of this, Bob, to try and maximize the number of insurance carriers who participate?

MR. CAREY: The intent is to recognize that carriers are concerned about risk segmentation in an Exchange model, and that that risk segmentation has an effect on price, and that we should be mindful of the

fact, if we set up a purchasing model that results in an overall increase in the cost of insurance for employers in Connecticut that goes against sort of a core tenant of the Exchange, is to make insurance more affordable, and, to bring in point number two, more employers to offer employer-sponsored insurance.

MR. McKIERNAN: Chris McKiernan. From a pricing standpoint, you know, what we see is that, for instance, in the current marketplace, if you were to have, say, a group of older individuals and dependent upon the pricing in, say, the Exchange program, if it was more of a community-based rate, I think the carriers would maybe have an issue, that if they were getting more of the business, due to that type of a rating issue, or is the small group marketplace as an age-based system, older individuals pay more than younger individuals, so just a pricing --

MR. CAREY: Right, so, there won't be community rating in the Exchange, in the SHOP Exchange. There will be modified community rating, which will apply both inside and outside the Exchange, the elimination of gender, the restriction on the three-to-one rate band, the restriction of use of factors, other than geography, tobacco, potentially wellness.

I mean there's sort of limits that will apply in 2014 inside and outside the Exchange, but the concern about risk selection is one that we've heard from the carriers. I think that it's just something for the Committee to consider. You might want to dismiss this guiding principle, but it's just sort of a factor for you to think about when you start to think about structuring a purchasing model.

If you want to achieve sort of more affordable coverage, more employers offering insurance, choice of carriers, you want to make sure that the carriers are willing to participate.

I know that my experience in Massachusetts was that carriers weren't really willing to participate in a broad choice, you know, employee choice model, where employees could go hither and yon, and it was comparable rating, modified community rating environment in Massachusetts that they were trying to roll that Exchange out into.

MS. BREAULT: Mary Ellen Breault. If I could just add something to address your pricing issue? Based on Connecticut State law, we would still have community rating with the adjustments. It will shrink, because of the case size and some of those other

adjustments that are no longer -- will no longer be allowed under federal law, would go away, but there will still be community rating.

And because there is a requirement, both in state law and even in the federal law, that if a comparable plan is offered, both inside and outside the Exchange, they have to be offered at the same rate, so there really will not be different pricing, you know, or pooling of those risks inside and outside.

I think it's more just, you know, you're just going to get more volatility if you have anti-selection.

MR. PUSCH: Tim Pusch. One other thing. We did mention this notion of, within a tin, you might see variation of product within that tin by carrier. Does that preclude the possibility that we could define the benefit plan in the tin, like CBIA does, and tell each carrier this is the product design and price it accordingly?

MR. CAREY: No, it doesn't preclude that.

MR. PUSCH: Okay.

MR. CAREY: So one of the decisions, one of the recommendations or issues that you'll tackle over the next couple of months will be do we standardize

benefits across the tins, and what are the ramifications of that?

MR. PUSCH: Okay. As long as it's an issue to address.

MR. CAREY: Yes, sir.

MS. O'GARA: So, given that -- I'm sorry, John. Go ahead.

MR. FLEIG: Yeah, this is John Fleig. I couldn't agree more with what Bob said from the carrier standpoint. This is a very, very big concern for carriers, adverse selection, and we're obviously trying to keep the prices down.

If we believe that this principle is taken out, you're going to see prices go up, because there is going to be adverse selection.

MR. McKIERNAN: What principle? I'm sorry.

MR. FLEIG: The principle we're discussing now, number three. If we take that principle out, prices probably will increase, because of adverse selection.

The other thing, the pools, both in and out of the Exchange, the rating is really one pool, so whether if a carrier participates both off Exchange and on Exchange, their small business has to be pooled

together for rating purposes.

MS. O'GARA: So isn't this -- I guess the follow-up on what you said is does this principle, then, send a message, that we are sensitive to the concerns of the carriers, but we're also sensitive to the cost of the coverage issue, and does the group think we should then leave it in?

VOICES: Yes.

MS. O'GARA: Let's try another one, if we could go to the next one. The SHOP Exchange should minimize any unintended disruption to the marketplace.

MR. KATZ: This is Matt Katz on the phone.

MS. O'GARA: Yes?

MR. KATZ: I'm not sure. I read this. I'm not sure what marketplace means. Is that the health insurance marketplace, the employer marketplace? I think we need to define what we mean by marketplace.

MR. CAREY: Yeah. The intent is the health insurance marketplace.

MS. O'GARA: Did you hear that, Dr. Katz?

MR. KATZ: It's Mister. I'm not a doctor, but thank you. I did hear that, and that would be good to I think include the word health insurance, or health insurer marketplace for consistency.

MS. O'GARA: Okay.

MR. KATZ: And clarity.

MR. FLEIG: Should we say -- this is John Fleig. The current small group marketplace, since it's specific to SHOP here? We are talking about the current market. We don't want to disrupt the current small group marketplace.

MR. CAREY: Correct.

MS. SKINNER: Could we add a definition to disruption? I'm not sure what we mean by -- this is Ellen Skinner. The word disruption. I think, if we're trying to come up with innovative ideas that may disrupt the current processes, but it may enhance those processes, as well, so I'm just -- I don't want to limit us in our thinking about what these models might look like.

MR. CAREY: Right. I put in the word unintended disruption. There will be disruption, but what we want to do is to disrupt the marketplace, so maybe we do need, you know, examples or something, or a different word for disruption, but I did want to point out that it was sort of unintended disruption to the marketplace.

MS. O'GARA: Could you give us an example,

based on your experience in another place, what might happen?

MR. CAREY: Yeah. I mean you could have a situation, in which the SHOP Exchange rolls out a purchasing model, or rolls out an option for employers that results in employees dropping coverage, or results in employers moving from their current distribution channel to the SHOP Exchange, and that has no net increase in the number of employers or number of employees that participate or offer coverage, or you could have a situation, in which you add costs to the system, without producing any net positive results, so you've disrupted the marketplace, you've added some cost, and you still have the same number or maybe fewer employers and employees purchasing coverage.

The view here is you don't want somebody to rearrange the way people get insurance just for the sake of rearranging things. You want to see a net increase in the number of employers and the number of employees that purchase coverage.

MR. FLEIG: So disruption. Another word for that, I think, is harm. We don't want to do any harm to the current marketplace.

MS. O'GARA: So I could see that you might

be sitting there, trying to make a decision about something, and one of you may say how does that fit with our guiding principle that says unintended harm? That's okay, as long as you all can internalize what that means.

Should we change the word to harm? Yes, Tim?

MR. PUSCH: Time Pusch. Does this mean that, in essence, we could potentially create a SHOP Exchange that would attract better experienced groups that are claim experienced groups, and the lesser good claim experienced groups stay out in the marketplace, therefore, disrupting from anti-selection the current marketplace?

Is that the concern that we're also trying to consider? Because there are some impetuses for people to come into the Exchange. My concern is that if the better groups do it, then it is going to disrupt the regular marketplace.

MR. CAREY: Well the fact that the carriers have to pool risk across, you know, inside and outside the Exchange for the groups somewhat minimizes the concern that you'll only attract either healthier or sicker groups to the Exchange.

Another issue, just as an example of

potential, you know, harm to the marketplace, if the Exchange says, well, we're not going to have participation or a contribution requirement, right, so, you've got some gaming that potentially goes on, in which employers, you know, of 10, in which only one employee wants insurance, is able to get in through the Exchange.

Those sort of examples are things you need to think about when you're setting up the structures. Not just the purchasing model, but it's all the rules that go on, and sort of the people, who were not familiar with it, would, you know, don't understand that there are reasons for participation and contribution requirements in the marketplace today, and that the SHOP Exchange needs to take those into consideration.

MR. McKIERNAN: Chris McKiernan. I think somebody may have said this, but did somebody say that the same, or very similar, if not, the same rules, will or should apply from the smoker marketplace as it is today and the Exchange marketplace? Did somebody say that?

MR. CAREY: Well I think that that's, certainly, that will be up for discussion. Do we want to mimic what goes on in the marketplace today?

MR. McKIERNAN: Another example would be

State-mandated benefits, just as a pricing, if you will, or benefit standpoint, that somebody had mentioned mental health levels, and it's an example of a State-mandated benefit, and there are, I think, 74 in the State of Connecticut right now, so I would assume that the Exchange plan will, by Insurance Department guidelines, have all of those mandated benefits in there?

MR. CAREY: Correct.

MR. McKIERNAN: I'm assuming that.

MR. CAREY: Correct. The plans that are offered through the Exchange will have to be licensed and reviewed and approved by the Department of Insurance and will follow all of the small group requirements that those outside the Exchange will have to follow.

MR. PINTO: Tony Pinto again. To give you a perfect example of something that we should be concerned with when going through this process, and it addresses both your points there, is when it becomes sensible for a group with 50 or fewer employees to become self-funded and opt out of the requirements of a mandated pool, so if the financial incentive becomes such that a small group can turn around and become self-funded and avoid most of the mandates and the other requirements, then, yes, it does create a detriment, because the groups

that it's going to make sense to be self-funded are the groups that are healthy, younger, and can handle the risk of a self-funded scenario.

And you're seeing that today with self-funding already down to 100 employees and even creeping down to 50 employees, which is the market that will, actually, this second phase, from 50 to 100, that is the great concern, is do we lose the healthy groups out of this and create a real nightmare?

MR. CAREY: Correct.

MS. MACIUBA: This is Marta Maciuba. Well, currently, in the market self-funding is going down to five, so that disruption is already occurring, so I think really one of the things about the SHOP Exchange is there are rules currently in place to cover employees down to 20 full-time eligible, and really the way, and I could be wrong, but the full-time employee guideline is 30, so there could be a difference, that you have 30 full-time in the SHOP, and outside market allows to start at 20, except, recently, I think we can now reinsure down to 20, so there are a lot of little nuances that you have to almost think of just from the very beginning to what you want to do in the SHOP versus out.

And I agree self-funding, as some states

have, and they don't allow self-funding under 50, and that may be something that we need to bring to the Board to say this could hurt the Exchanges overall if that occurred.

MS. O'GARA: I think that's a good example, Marta, of the use of the word unintended, so, as you're looking at these things, you're thinking through a series of checkpoints to make sure there aren't any unintended harms.

So we'll leave it like that. I want to remind you that we're going to bring these back to you. You're going to have a chance to look at these again. This is, I think as you stated it, Pam, for all of us to understand what we're talking about.

Let's move onto the next one. The SHOP Exchange should minimize the administrative burden on employers, employees and insurers. Marjorie?

MS. COLE: Marjorie Cole. It should just minimize administrative burden, period.

MS. O'GARA: Period. We could shorten it. Chris?

MR. McKIERNAN: Could you get into that a little bit? What does that mean?

MR. CAREY: Well, from the perspective of

an employer, to make the SHOP attractive to employers, it has to be easy to operate and administer, so you don't want to set up a cumbersome process that would turn off employers to even participate on the SHOP Exchange, and we've seen examples of that in other states, where they've set up an apparatus, and it's just too confusing for employers to figure out, and they decide they're just going to continue to offer coverage through my current venue.

From the perspective of employees, it gets, I think, to Tim's point with regard to choice, and if there's too much choice, or if it's confusing for employees to try to figure out what my options are, that adds an administrative burden to those employees, in terms of their ability to participate.

And then, from the perspective of an insurer, you know, these are all potentially additional costs. What we're trying to just get the group's head around is the fact that any additional administrative burdens or costs that you put onto the carriers will simply be reflected in the premiums that the individuals and the employers and employees pay, so we just want to be mindful of not overburdening anybody in the equation, as you think about structuring the SHOP Exchange.

And I think that, you know, the Utah Exchange, for example, allows, you know, insurers to participate, doesn't really restrict the types of plans that they can offer. Humana participated for a little while, and then, in October of this year, said you know what? The administrative burden is just too much, and we're not getting enough volume out of this engagement, and, you know, if they did a calculus and decided to opt out of the Utah Exchange, so it's just sort of an example of how administrative costs and requirements can result in less choice for employees and insurers dropping out of the marketplace.

I mean the other thing just to keep in mind is this is a purely voluntary marketplace from the perspective of both employees, employers and insurers. Insurers don't have to participate on the Exchange, in general, and on the SHOP Exchange, in particular.

MR. FLEIG: This is John Fleig. I appreciate Marjorie's comment, however, in my opinion, so there's no confusion, I would leave the three in there to show that it shouldn't have a burden on any of them, so there's no question, because you could just read it an administrative burden on who? Is that just the employer?

MS. COLE: In fact, I would like to

(multiple conversations) or you can expand upon it, because any time you put an administrative burden on it. Let's say the employee goes to his or her physician, and there's additional administrative burden, the physician needs to do something, the physician starts saying don't join that, don't do this, I have to do A, B and C for you now, it becomes -- it all just snowballs into what happened, as you said, in Utah, where it all falls apart, so that's the only reason I said take -- because I think that's limiting. Having those three on is limiting.

MR. CAREY: Maybe an option is, you know, including, but not limited to, employees, employers and insurers. That way, it's all inclusive, but you also are recognizing that there are three, in particular, groups that you're mindful of.

MS. PULISCIANO: Patty Pulisciano. I would just say something like all involved, because the consumer is involved in this, too. If you make it so difficult for the consumer or employee in this case, then that becomes a hindrance, as well.

MS. COLE: Right. It doesn't have to be the employee. It could be the spouse.

MS. PULISCIANO: Right. That's what I'm saying, for all involved.

MS. O'GARA: So, then, our last one here is, whenever feasible, the SHOP Exchange should leverage existing resources and technology to keep costs down, and there's a general agreement.

A MALE VOICE: Agree.

MS. O'GARA: Okay. I just want to make sure we haven't missed anything that you might be thinking about, so, since this is the first time you've really had a chance to have at it, we'll get this out to you ahead of time, and you may think of another one or shortening these up, okay?

MR. KATZ: This is Matt Katz again. I'm sorry. It's hard to jump in from the phone. Did I hear that you were changing or suggesting you change a -- add something about cost burden? Is that correct?

MS. O'GARA: The last one we didn't change. It's stated as it is, to leverage existing resources and technology to keep costs --

MR. KATZ: No, the one before that.

MS. O'GARA: No, we didn't add cost burden. The cost came up in the third one.

MR. KATZ: I guess I apologize. I heard the first comment in that bullet, number five, being about concerns of costs. I would change it to not cost

so much as financial burden for the administrative and financial burden, but that would be my only suggestion to that one. I'm sorry.

MS. O'GARA: Thank you. And how does the group feel about that, adding financial, administrative and financial burden?

MR. FLEIG: John Fleig. I think that's fine.

MS. O'GARA: Good? Okay. We'll add it. All right, thank you. And I think, then, that concludes our discussion on the guiding principles.

We want to spend some time now talking about the specific tasks of this group, so we have a good grip on that.

MR. CAREY: Okay, so, let's sort of map this out. Largely related to sort of deadlines that the Exchange faces with regard to making decisions on some of these key points, as well as a recognition that, you know, carriers will have lots of changes to make between now and 2014, in terms of the products that are offered in the individual and small group market, as well as the large group market, and, so, for example, as the Exchange goes to the market to solicit participation by carriers, we've sort of mapped out a rough schedule about when that

has to occur, and, so, for example, the essential health benefits need to be set by the State by September of 2012.

Just so folks understand what that means, the law requires that products offered in what's called the non-grandfathered individual and small group market need to cover a package of services and benefits that are called the essential health benefits.

The law directs the Secretary of Health and Human Services to further define those essential health benefits, so the law, itself, lists out inpatient care, outpatient care, prescription drug coverage, mental health and substance abuse, office visits, ambulatory care, 11 different categories of services.

It then says, oh, you, Secretary Sebelius, you need to further define what fleshed this out, in terms of what exactly is covered under the essential health benefits.

In December of this year, the Secretary of Health and Human Services issued a bulletin to the states that sort of pushes it back onto the states to make that decision with regard to what does Connecticut and what does Rhode Island and what does New York deem to be the essential health benefits within certain parameters set

out by law and in that guidance.

So the State has a decision to make about which of the, there are four plan types, will be the Essential Health Benefits Package for Connecticut, and that decision needs to be made by September of 2012. If not, the feds will make that decision on behalf of the State of Connecticut.

So one of the areas that we'll want this group to review and comment on is, of the options available to Connecticut, which one is best for the essential health benefits for 2014 and 2015?

MR. PUSCH: Tim Pusch. Would those essential health benefits, therefore, be pegged by that Platinum, Gold, Silver, Bronze ranking?

MR. CAREY: Right, so, the essential health benefits are exclusive of cost sharing, so the cost sharing really is the Platinum, Gold, Silver and Bronze.

Every plan, be they Gold, or Silver, or Bronze, will have to cover --

MR. PUSCH: They all have to be essential health.

MR. CAREY: They all have to cover the essential health benefits. The distinction between the

plans will be how much is paid out-of-pocket and how much is paid for by the premium?

MR. PUSCH: And one more thing on that particular issue. Will the essential health benefits have to entail all of our State mandates?

MR. CAREY: That's a decision that is available to the State, so that the State -- there are four plan types, four groups, I guess, of plans that the State can choose from, in terms of their essential health benefits.

There's the small group plans with -- three small group plans with the largest enrollments in the State is you could pick one of those plans for the essential health benefits.

You could pick the largest HMO, in terms of enrollment in the State, you could pick the State employee's health benefit plan, or you could pick the federal employee's health benefit plan with the largest enrollment, and that benefit plan, you know, supplemented, if necessary, if it doesn't cover certain essential health benefits.

For example, pediatric dental, which isn't typically covered in a health plan, you'll need to supplement it potentially with some benefits, and

habilitative services is another requirement of the ACA that's typically not covered, so the State could choose, for example, the federal employee's health benefit plan as its essential health benefits package.

It's quite likely that there are State mandates that aren't covered by the federal employee health benefit plan, and, so, in that instance, the State would need to make a decision.

If that's the benefit plan that we are going to choose as our essential health benefits, it would likely require, or it would require that any mandates that exceed that essential health benefits would have to be paid for by the State, so there are certain issues that the State will need to get their head around and make a decision about the essential health benefits.

That doesn't mean that the mandates wouldn't be part of the plan that's sold on the Exchange. What it would mean is that there would be a fiscal note attached to the decision to choose the federal plan, as opposed to a small group plan that's offered in Connecticut.

MR. FLEIG: Who is the State here, the legislature or the Board, the Exchange Board?

MR. CAREY: Well because this has

ramifications and applies across the individual and small group market, it's not just the Exchange Board that will weigh in, but we think that given the expertise of the Advisory Committees and the responsibilities of the Exchange Board, that the Exchange weigh in and make a recommendation.

I think what will happen is it will fall to -- the letter or the directive was to the Governor of the State, and, so, whether that requires legislative action or not is to be determined.

MS. RUSSEK: Pam Russek. I was wondering, Bob, if you or anybody thus far on behalf of our State has done any of the mapping, so that when any of us are considering what content is in the benefit plans and even things like where the law allows you to in 2014 and 2016, that some of those issues that we might be deciding on now we sort of don't mortgage the future by making too much of a major kind of decision, so is there going to be data provided, so that is clear to us?

MR. CAREY: Yeah. So we, working with the Insurance Department, have sent a survey to carriers that received information back from the carriers. We're assembling essentially a spreadsheet that lays out the benefits and then what's covered by, you know, each of

those plans, and that will be part of -- what we'll do is put together what I call an issue brief that explains the issue, that then documents and lays out what the options are and what the differences are across the small group plan, the large HMO, the State employee plan and the federal employee health plan.

MR. PUSCH: Is that the May issue point that's second on our list?

MR. CAREY: Yes, sir.

MS. O'GARA: Mary Ellen?

MS. BREAULT: Just to add to that, too, the federal government actually has collected data from a lot of the carriers, so in the small employer market, they did provide their picks, based on the data that they received last December, but that was only an example to show how, you know, their process was working.

And they do intend to come out with the next set, the final set, and we're hoping that we don't have too much discrepancy, but they are aware that, in some states, based on what they have presented before, there were some issues, so we're working very closely with the federal government on some of those things.

And just one other point is these are plans that were really ready to be (background noise) of

this year, so part of the guidance that came out are any new mandates that are enacted after December 31st of 2011 cannot be considered part of the Essential Benefit Package, so anything that gets passed in this legislative session would have to be covered under these plans, but would become the liability of the State, so that's something to keep in mind.

MS. RUSSEK: And just as a follow-up, this is Pam again, so I want to go back to the self-insured issue, because it sounds like that one is moving. So do we manage all issues? It's not just benefit plan design? It would be anything pertaining to how we make decisions relative to the whole package?

MR. CAREY: Right, so, our approach will be that, you know, prior to the meeting, you'll get information in the form of an issue brief, or if there was a report from another state that might be helpful, or a report from the feds.

We'll provide you with information upfront. We'll try to keep it to a manageable size, and then, at that meeting, we'll walk through a presentation, and then have an opportunity for discussion on the issue.

COURT REPORTER: One moment, please.

MS. CINTRON: So we'll talk about this a

bit more for the next meeting. The insurance survey will be given to you we hope by April 30th at the very latest, along with an Essential Health Benefits briefing.

MS. RUSSEK: And that's a point that Tony made earlier. I was wondering if maybe we could, as part of the notes or whatever, point to when there's source information, that if any of us wanted to look at a more robust version, that we could be provided with links or whatever.

MR. CAREY: Yeah.

MS. RUSSEK: Okay, great.

MS. CINTRON: Yeah. We want to do that and, also, suggest some of the like best practice, because there's a lot of information out there, as you know.

MR. PUSCH: Tim Pusch. That survey that I guess you say that sort of has been conducted already?

MR. CAREY: Yes.

MR. PUSCH: The CID survey that you're referring to?

MR. CAREY: Yes.

MR. PUSCH: Will we understand the basis of the survey when we get that information? For instance, is it just the most popular plans, or whatever

parameters would be involved in how they conducted that survey?

MR. CAREY: Sure.

MR. PUSCH: Because I did a little informal one on my own to get a sense of where the market was, and I just would want to know what their basic position was, in terms of how they did the survey and what they were concluding those results based on.

MR. CAREY: Sure. Exactly. Right.

MR. PINTO: I have a question for you.

MR. CAREY: Yes, sir?

MR. PINTO: Tony Pinto again. Just a point of clarification. Because there's four Committees, I don't know how deep we're actually going to get into benefits, but there is a Committee that's primarily working on benefits.

MR. CAREY: Right, so, this is this issue that we think it's important for this Committee to be apprised of, you know, this essential health benefits issue, particularly as it applies to the small group market.

The Qualified Health Plan Committee is sort of the, you know, you can think of it as the prime contractor and the sub-contractor, and they're the prime

contractor, and they'll be making recommendations, but we think that it would be important for this Committee to weigh in or to review their recommendation as it rolls forward, so that's how we plan to do that.

MS. O'GARA: We're getting a little feedback. I think paper moving from the listeners. Thank you.

MR. CAREY: Okay, so, essentially, the May meeting will focus really on the essential health benefits, and you'll be able to review that, and information will be received from the survey or the carrier, so you get a feel for what the small group market looks like today.

In the June meeting, I think that the focus will largely be on the cost sharing requirements at each of the qualified health plan levels, so we'll go through and sort of walk you through that, and then, also, have a discussion about the merits or lack thereof of standardizing benefits at each of the metallic tiers.

I think we also need to discuss the potential to offer different plans in the small group market or the SHOP Exchange than might be offered in the individual Exchange.

In other words, you look at it, they're

two distinct markets, they're pooled separately by the carriers, and we'll want some discussion around whether there's a need for different products offered in the small group market than might be offered in the SHOP Exchange.

MR. PUSCH: Well, if I understand correctly, there are different State mandates for the small group than there is for the individual.

MS. BREAULT: Mary Ellen Breault. For the most part, in recent years, they really are the same. There are a few minor differences, but they're pretty close.

MR. CAREY: But to that point and, also, to just sort of the general structure of the types of plans that you might offer in a small group market that might be different (papers on microphone).

MS. O'GARA: Excuse me. It sounds like there's a train going through. Hello? Could you mute your phones? Thank you. Can you hear us?

MR. RITTER: Hello?

MS. CINTRON: Hi, Grant?

MR. RITTER: Yes, I can hear you now. I was lost for about 10 minutes there, but I'm back online.

MS. CINTRON: We're hearing a lot of the

static.

MS. O'GARA: We're hearing a lot of static, so if you could mute your phone?

MR. RITTER: Yeah, it is muted. That's why it's taking longer to answer you, but I'm hearing typing, also, and I don't think it's at my end. I think there's some interference there.

MS. O'GARA: Okay. Thank you.

MS. CINTRON: Okay.

MR. CAREY: Okay, then, July we'll get into this issue of the options and recommendations regarding plan designs, and, so, we'll tee that up at the June meeting, and then hopefully be ready to make recommendations on plan designs, as well as the number and types of qualified health plans that may be offered in the SHOP Exchange.

Again, the Qualified Health Plan Committee will be working on this issue, as well. We think your focus is really on the small group market, and we'll be able to offer some good insight and thoughts on how the small group Exchange might be structured and whether that's different than the individual Exchange.

You don't get a break in August, although we might choose to, but in terms of deadlines, we think

that by September we need to think about, you know, what are the certification criteria?

So one of the provisions of the ACA is that the Exchange shall offer plans that are in the best interest of individuals and employers, and there are a number of criteria laid out in the law and further defined in regulation, and we'll review those and discuss whether Connecticut wants to add more criteria to the manner by which the Exchange solicits and certifies qualified health plans to be offered to the SHOP Exchange.

And then we'll also review and comment on the evaluation criteria that should be used to determine whether a plan satisfies the requirements of a qualified health plan, so we'll walk through that, as well, in terms of how we structure the solicitation.

So, you know, the Exchange won't be a purchaser of insurance. The Exchange is a facilitator of insurance, but it will need to issue a solicitation to the carriers to lay out what are the requirements and what are the criteria that will be used to determine whether a plan is offered or not by the Exchange.

And then, you know, we wrap up in October with a number of key decisions, and we won't -- I think

we'll likely spread out the discussion of these over the course of the next several months, but, by October, we'll need to make decisions about participation and contribution requirements, so we'll review what the requirements, or what the rules are, or the standards that the carriers use today, any requirements under the Department of Insurance, and determine what the rule making will be or the requirements will be inside the Exchange with regard to both participation and contribution requirements.

We'll make a decision about this employee choice purchasing model, which we talked about earlier, about how much choice and how to structure that, and that will be important to include in the solicitation, because the carriers will want to know, if they're going to participate in the small group Exchange, what are the rules of the road, in terms of the employee choice purchase model that's available?

It's also the issue of the potential to expand the small group market prior to 2016 to groups of up to 100. Mercer has done some preliminary work on that. We're going to take a deeper dive.

This issue of self-funding is a major one, and it has ramifications that are much broader than the

SHOP Exchange, and we've been talking with the Department about that, and we'll want to bring that up as part of this discussion.

One of the things that we think that this Committee, in general, but, in particular, in the Exchange, in general, is that it helps to educate people about what's happening in the marketplace and bring to light some of these key issues.

And I think this issue of self-funding in the small group market is one that we'll want to highlight and to just recognize that it's happening, and what are potential ramifications for the fully insured market as you begin to see more migration of groups, from fully insured to self-funding.

And then, also, some of the rules about carriers or employers being able to purchase coverage in the fully-insured market. If there's continuous open enrollment, essentially, for small groups, people can flip back and forth between self-funding and fully-insured, and it may have a major disruption in the small group market.

I think one thing, even if we don't, even if it's not our place to recommend or to make decisions on something, I think just highlighting the issue could

be of (coughing).

MR. PUSCH: Excuse me. One thing. I want to clear up something about the self-funding, because self-funding really does occur in larger groups. This form of self-funding is a little more insidious. It is designed to cherry pick the healthier groups. It's not a true self-funding arrangement.

It's simply saying, if you're a healthy group, we're going to price your premiums lower, and if, in fact, you happen to have better claims experience than even we are predicting, we'll refund you premium dollars.

That is not a true self-funding arrangement. It is simply saying, if you are a healthier group, you will pay lower insurance premiums, and they do that judgment upfront, literally collecting health data from the individual employees, so it has a more insidious impact, I think, in terms of cherry picking, from the whole state pool.

MR. CAREY: Yeah, you know, some states, I think Delaware, Oregon and New York, prohibit essentially self-funding in the small group market. That's an option.

There are other ways to address that. There could be the issue of at what point is the

attachment point too low to really qualify as truly a self-funding arrangement, and that's another approach that states are considering taking, is to raise the attachment point and to have a regulation and a requirement that you can't operate, you can't offer, you know, reinsurance at $5,000 per person, because that's just a high deductible health plan.

I think that this will be a good body to discuss those issues and to raise really what the ramifications are, as you mentioned.

And then the final piece is the assessment of whether to merge the individual and small group market, so, in the statute, one of the requirements is that the Exchange make recommendations on whether to merge the individual and small group market as part of this group's charge.

We think it's the proper venue to discuss the merits and the tradeoffs associated with merging the individual and small group market.

Massachusetts is the only state that I know that has a truly merged individual and small group market. Other states that have looked at it have decided that they want to keep them separate.

This issue is raised largely, because

under the ACA it sort of directs states that they can do this, although states have always been able to do this, so I wonder why they decided to emphasize that you could still do it, but it's an issue that we need to address as part of the report to the Governor, which is due at the end of calendar 2012, and we'll want this group to weigh in and discuss the merits of that.

MR. PINTO: Tony Pinto again. I didn't know if you had an update on that, but, before you answer, I did want to point out one thing. It is impactful here, because, with guaranteed issue, you lose both Health Free and the CSERP plan, so those two groups can go to the individual market or the small group market, so if they're merged, the question is how do you balance it out? Do you have an update?

MR. CAREY: No, I don't have an update, other than that's just one issue that needs to be considered, as you think about -- you know, there's lots of changes that will occur in 2014.

Our initial assessment was that it may make sense to see how the market shakes out, but we'll want to at least go through and discuss these issues, including the high-risk pools that are currently operating in Connecticut.

MR. PUSCH: Point of clarification. Is a one-person business considered a small group or an individual from the standpoint of the Exchange, or has that not been defined?

MR. CAREY: I think that the feds have weighed that it's groups of two or more, essentially. That's sole --

MR. PUSCH: Okay, so, solo op. is considered an individual?

MR. CAREY: Individual, yeah.

MR. FLEIG: But couldn't the State come up with their own rules? I'm not advocating that.

MR. CAREY: I'll make note of that, John. (Multiple conversations) So an employer with an employee, is that a group of one, or is that a group of two?

MR. PUSCH: Two.

MR. CAREY: And, so, in the small group market, it's two to 50?

MS. BREAULT: Well I know there is some language with regard to sole proprietor, and if it's a family member, you know, there are some issues there. I do not believe they view that as a group.

MR. CAREY: As a group, right.

MR. PUSCH: Pardon me? What did you just say?

MS. BREAULT: I thought there was a sole proprietor under the federal law that's not being viewed as a group if it was a family member or as an employee. There's some discussion in the regulation.

MR. PUSCH: Okay, not state, though?

MS. BREAULT: Not state, no. In the state law, sole proprietors are viewed as a group of one.

MR. PUSCH: And are included in the individual market or the small group market?

MS. BREAULT: Small group market. If they buy an individual policy, they can, with disclosure and a sign-off, say they understand they're purchasing an individual policy, and they're outside of the protections of the small group clause, so they actually do have a choice.

MR. PINTO: This is Tony Pinto. Maybe I can clarify a little. In Connecticut, you can be a small group of one, a sole proprietor, and buy through the group plan, because your guaranteed issue is a group of one. You get the CSERP plan, if nothing else.

Otherwise, you're probably, today, if you're uninsurable or have preexisting conditions, you're

not buying in the individual market. You're going to CSERP, or you're pretty much staying without coverage, or going to Health Free.

So, in Connecticut, it is, as a sole proprietor, you could be a group of one. Now if it is a family member, and this happens all the time, in order to get a group guaranteed issue in Connecticut, if the spouse is working, you give both spouses their own contract, and they're now a group of two contracts, and they have guaranteed issue, so you see a lot of groups of two contracts to get the guaranteed issue to not have to put them in the CSERP plan, so that's why it's very cautious, because what you're talking about is the federal regulations saying group of two or more, but, in Connecticut, it's group of one to 50.

If you had guaranteed issue in group of one, you wouldn't need group of one. You'd just buy insurance directly, because you don't have to worry about preexisting condition, so that's why the preexisting condition and guaranteed issue changes the marketplace.

MR. CAREY: Okay, so, I think that's sort of the overview of your tasks. Again, the way we'll try to walk through these is that we'll send you information ahead of the meeting, hopefully for you to have some time

to digest that. We'll, then, at the meeting walk through the presentation and have open dialogue.

MS. O'GARA: So we have a couple of things to finish up on. We have a Committee meeting coming up. We'll talk about the date in a minute, but some of the things that Bob has just mentioned to you we already put on the agenda for next meeting, which is this carrier survey and, also, the EHP summary.

We're going to bring the guidelines back to you. One of the other committees has asked for some information about some of the carriers' concerns, and I think we're going to collate a number of documents and interviews that have been put together, so you all can see what some of their concerns have been, so those will all be sent out to you ahead of time, you'll have a chance to review them, and then we'll have them on the agenda for next meeting.

Next meeting, so we --

MR. PUSCH: Before you get to that, can I ask a question? Do we have any sense of what entities may be surfacing above and beyond the carriers that are actively operating in the State of Connecticut right now?

Do we have any sense of any additional entities that might surface?

MR. CAREY: Any entities, in terms of carriers that might enter the marketplace?

MR. PUSCH: Yes. For lack of a better term, yes. New entities that might be -- you mentioned something about the Connecticut Medical Society that might be creating some sort of a --

MR. CAREY: Co-op, correct.

MR. PUSCH: Yeah.

MR. CAREY: So they're thinking about trying to create a co-op that would be offered in Connecticut. I don't think they've yet received approval from the federal government, but that's one.

MR. PUSCH: I'm just wondering if we have anything to think about beyond what's in place today, in terms of carriers.

MR. CAREY: The other is that, you know, according to the law, OPM, the Office of Personnel Management, not this OPM, the other OPM, the federal OPM, is supposed to solicit and make available to all of the Exchanges a nationwide, two nationwide plans, one non-profit and one for-profit.

I've not seen any movement from OPM with regard to that process, but that was supposed to be part of the ACA, as well. I don't know anything further. I

don't know if, John, you know anything.

MR. FLEIG: Right. Part of that is it's over four or five years the carrier has to be in every state.

MR. CAREY: Okay.

MR. FLEIG: So it's just not picking state-by-state, so that's something the carriers have to look at. Could we actually do this in 50 states within it's either four or five years?

MR. CAREY: Okay, so, that's another option, potential.

MR. PUSCH: It doesn't sound like it's an immediate concern, though.

MR. CAREY: It doesn't sound like it's of immediate concern, no.

MS. O'GARA: Okay, so, with respect to the next meeting, we've tried a couple of dates out with some of the other Committees, and what we're trying to do is get two days sequentially, and I think the best thing is going to be to send out what we call a Doodle, which is an e-mail, and we figure out what the maximum participation is.

We're thinking about the week of -- that has the 8th and 9th, and we're also thinking of the

following week, so those will be about 30 days from today, and we'll get something out to you and figure out what that is, so you can get it on your calendar.

MS. COLE: Could we schedule a couple of those at a time?

MS. O'GARA: Yeah. I think we could send out an e-mail for May, June, July, maybe try to get those nailed down.

MR. CAREY: Initially, what we tried to do is basically every 30 days. Those would be early June, early July, early August, so that would be our -- my preference, as well, to schedule something at least a couple of months in advance.

MR. PUSCH: So no vacations this summer?

MR. McKIERNAN: We'll try to be present at the meeting, but if, for whatever reason, can we call in?

MS. CINTRON: Yeah. Hopefully, we will have better choices of rooms, too, so, acoustically, this will be a little easier.

I just wanted to mention, too, that the Exchange will continue to support this process logistically and material-wise, and the role of the co-Chairs will kind of ramp up, if you will, in the next meetings, as between the meetings there will be things to

consider, and the two co-Chairs will be tasked with kind of pulling you all together and discussing things in between the meetings.

Any comments, Pam, or questions around that?

MS. RUSSEK: No. I think that sounds fine. One question I was going to ask of Bob was simply, and maybe Bob is not the right entity, but as we go over this material and before we have the meeting, would it be helpful to the discussion, in terms of productivity, to send in questions ahead of time, so that it might help shape the agenda, so we don't spend time on stuff and everybody is sort of yeah, yeah, I get that part versus the things that maybe, as you guys look at this, everyone looks at it, and it resonates something, in particular, and you want to pursue it more. Maybe we could focus the discussion on those pieces.

MS. CINTRON: No, I think that's very helpful, and we can listen to you and your group's input and try to be responsive to that.

MS. RUSSEK: Yeah, because, that way, as Grant and I try to get folks together and we start talking, we could probably come up with several different themes that we run by everyone and just say, you know,

this would be where it was beneficial for our group to spend the most time.

MS. CINTRON: Great.

MR. PINTO: This is Tony Pinto. Would you like me to send you the link to the subsection on Kaiser Family Foundation website with the reference materials or no?

MR. CAREY: Sure, you can do that, but we have gathered a bunch of information, as well, but, yes, why don't you send that one? We don't want to -- and we'll send that out, we'll try to be somewhat judicious in the materials that we send you.

Sometimes getting too much information is worse than getting too little information, because you just don't go through it, but we'll try to pick and choose reports from other states, or national foundations and others that have looked at this.

One state that we've looked at, in particular, that I think did a nice job in a similar structure was Maryland, where they went through a similar process, and, so, in particular, you can expect to receive their SHOP Exchange report that they put together. They've walked through many of the same issues.

MR. PUSCH: Did they do this before this whole thing is occurring?

MR. CAREY: No. They did it in the fall of 2011.

MR. PUSCH: So they're just ahead of us?

MR. CAREY: They're just a few months ahead of us, right, so they did it in September and October and had a report.

MR. FLEIG: It's even earlier than that. I actually co-Chaired that one. We started last summer and finished up like September.

MR. CAREY: Oh, okay. I thought it was the Exchange -- the Maryland Exchange had, in statute, had a number of reports or issues that they needed to report back to the legislature on, so that was sort of the time frame.

That's why they had to move that quickly forward, so that they could meet their December 2011 deadline to report to the Governor to then report to the legislature, so we'll send you that report. I think it's a helpful one.

MS. O'GARA: One last item, Pam and group. We do have some time for public comment that we usually allow at the end of the meeting, but I don't know if

there's any public here. You all are KPMG?

A MALE VOICE: That's correct.

MS. O'GARA: Okay, so, we won't need to do that today.

MS. CINTRON: So unless there's anything else? Again, we appreciate your willingness to engage here. It's a big task, and we're going to keep you guys busy. Thank you.

MS. O'GARA: Thank you.

(Whereupon, the meeting adjourned at 3:48 p.m.)

RE: CONNECTICUT HEALTH INSURANCE EXCHANGE
APRIL 11, 2012

AGENDA